

**Thrive OT Referral Form**

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| Patient Information | | |
| Patient Name:  NHI#:  ACC Claim #: | Referrer’s name | |
| DOB | GP Name | |
| Address | Practice Address | |
|  |  | |
| E-mail | Phone | |
| Phone | Fax | |
| Brief Medical and Social History | | Medications  (if relevant. e.g. psycho-active/analgesic) |

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| Reason for Referral for Occupational Therapy  TICK TICK | | | |
|  | Home Environment Assessment |  | Wellness Management: healthy routines/habits  e.g. exercise, sleep, eating habits, stress management etc |
|  | Falls Prevention Intervention |  | Engagement in meaningful activity/  Problem solve barriers to participation |
|  | Independence and Safety training  e.g.: performing daily tasks in home/community |  | Role Transition. e.g. Retirement, caregiver,  dependent, loss of drivers license |
|  | Community Participation/Socialisation |  | Work/Productivity |
|  | Education in strategies:  fatigue/pain, stress/anxiety, managing disability etc |  | Other |
| Other Relevant Info.  Expected Outcome: | | | |

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| Funding Source (please circle applicable source) | |
| Patient Privately Pays | Acute Demand/ Care Plus/ |